ALLERGIC RHINITIS WORKSHEET

EXAMINING FACILITY:	FACILITY UIC:
TODAY'S DATE:	EXAMINER'S PHONE #:
REQUESTING WAIVER?	REQUESTING TO ELIMINATE WAIVER?

HISTORY

	SYMPTOMS		FREQUENCY		TREATMENT		PRIOR PROBLEMS
	RHINORRHEA		SPRING		None		EAR BAROTRAUMA
	CLEAR		SUMMER		OTC Med		SINUS BAROTRAUMA
	CLOUDY		FALL		Steroid Spray		SINUSITIS; CHRONIC? RECURRENT? ACUTE?
	LACRIMATION		WINTER		Rx. Med*		OTHER:
	SNEEZING		PERENNIAL		AIT**		
	CONGESTION						
	ITCHING						

How many years of sx.? Typical duration of sx:

CURRENT SYMPTOMS (if no sx. at present, when was pt. last symptomatic?):

CURRENT THERAPY, IF ANY: *(LIST MEDS) PAST EFFECTIVE THERAPY:

**IF HX. OF ALLERGY IMMUNOTHERAPY, DATE BEGUN:	DATE COMPLETED:

PHYSICAL EXAMINATION

RIGHT EAR:	VALSALVA?
LEFT EAR:	VALSALVA?
NOSE:	
MOUTH:	
OROPHARYNX:	

SINUS FILMS RESULTS: (Include actual films if abnormal / **submit all films on APT applicants**)

ENT EVALUATION: **(ONLY IF REQUIRED PER WAIVER GUIDE)**

ALLERGY EVALUATION**: (ONLY IF REQUIRED PER WAIVER GUIDE)**

IMPRESSION:

FLIGHT SURGEON'S RECOMMENDED DISPOSITION

	NPQ, WAIVER RECOMMENDED		PQ, DISCONTINUE WAIVER
	NPQ, WAIVER NOT RECOMMENDED		

FLIGHT SURGEON SIGNATURE/ STAMP		
PATIENT'S SIGNATURE:		DATE:
PT'S NAME: LAST/ FIRST/ MIDDLE/RANK/RATE		
DATE OF BIRTH: AGE:		SSN: